

Lyme Borreliosis Surveillance Form

Texas Department of Health / Infectious Disease Epidemiology and Surveillance Division
1-800-252-8239

Case No. _____ Patient Phone No. _____

Patient's Name _____ Birthdate _____ Sex _____

Address _____
(Street) (City) (County) (Zip)

Race: White __ Hispanic __ Black __ Asian __ Native American __

Physician's Name & Telephone No.: _____

Does the physician consider this a case of Lyme disease? Yes__ No__ Unk__

SKIN MANIFESTATIONS

1. Did the patient have erythema migrans (EM) ? Yes__ No__ Unk__
(red circular expanding lesion(s) with central clearing)

If Yes: date of onset of initial EM lesion: _____
(month, day, year)

- a. Diameter of largest lesion: _____ inches
- b. Number of lesions: _____
- c. Location of lesion(s) _____
- d. Did initial lesion occur at site of a tick bite? Yes__ No__ Unk__
- e. Date tick removed: _____
- f. Was the EM diagnosed by a physician? Yes__ No__ Unk__

2. Was the EM accompanied by fever? Yes__ No__ Unk__

3. Was the EM accompanied by headache? Yes__ No__ Unk__

4. Did the patient have other skin lesions or rashes (not EM)? Yes__ No__ Unk__

If Yes: was the rash: (Indicate the type(s) that apply)

Macular__ Papular__ Petechial__ Urticarial__ Pruritic__

CARDIAC MANIFESTATIONS

1. Did the patient experience any of the following manifestations?

- a. Conduction defects / Heart block..... Yes__ No__ Unk__
- b. Left ventricular dysfunction..... Yes__ No__ Unk__
- c. Myocarditis..... Yes__ No__ Unk__

NEUROLOGIC MANIFESTATIONS

1. Has the patient experienced any neurologic manifestations?.. Yes__ No__ Unk__
(Please indicate the manifestations below)

- a. Bell's palsy (If Yes: Was it unilateral or bilateral? _____)
- b. Facial paralysis
- c. Encephalitis
- d. Hearing impairment
- e. Meningitis
- f. Sensory impairment
- g. Limb weakness
- h. Confusion
- i. Vision impairment

2. Has the patient experienced any tingling, numbness, burning or
stabbing sensations (neuropathy/paresthesias) in the arms or legs? Yes__ No__

ARTHRITIS

1. Did the patient have swelling in any joint? Yes__ No__

If yes: date of onset: _____
(month, day, year)

2. Did the swelling migrate (move around) from joint to joint? Yes__ No__

3. Has the patient been diagnosed with temporomandibular joint pain? Yes__ No__

4. Did the patient have only pain (not swelling) in any joint? Yes__ No__

OTHER DATA

1. Was the patient hospitalized?..... Yes__ No__

2. Was patient treated with antibiotics? Yes__ No__ Type: _____

3. Known tick attachment in the month prior to illness? Yes__ No__

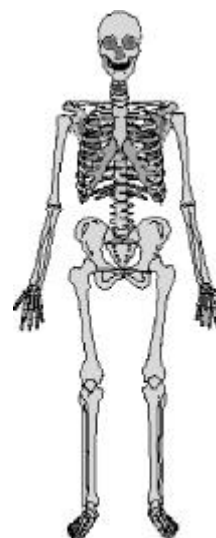
4. Where (county/state) was tick exposure? _____

5. Known flea bites in the month prior to illness? Yes__ No__

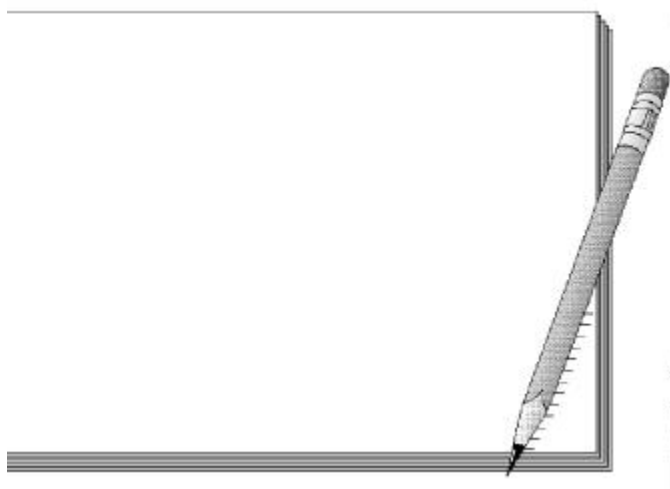
Please circle swollen joints on the below figure:



Please circle painful joints on the below figure:



C
O
M
M
E
N
T
S



LABORATORY RESULTS

1. Lyme Test Results:

Date Collected	Specimen Type (serum, CSF, urine)	Method Used (IFA, WB, normal value, ELISA)	Test Results

2. Syphilis serology results: Type of test_____ Date:_____ Result_____

3. Rheumatoid factor: Date:_____ Result_____

4. Antinuclear antibody (ANA) : Date:_____ Result_____

5. If spinal tap was performed, provide date and findings. Date:_____

WBCs:_____% Lymphocytes:_____% Neutrophils: ____% PAM cells + monocytes: ____ Protein mg/dl: ____

Glucose mg/dl: ____

Investigated by _____ Date_____ Agency_____